VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ Exception to Required 90 Day Maintenance Medication Fill ~

Prior Authorization Request Form

Each time a drug is dispensed, a dispensing fee is paid to the pharmacy. Pharmacies are now required to dispense designated classes of maintenance drugs in 90-day supplies after the first fill. This will result in a savings to the Medicaid program of $9.50 per prescription and therefore enable us to direct a greater portion of our resources to providing the medication our beneficiaries need rather than continuing to direct these funds to the administration of the program. The list of the classes can be found at: http://ovha.vermont.gov/for-providers/maintenance-medications-subject-to-90-day-refill-rule.pdf. To request an exception, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

- Requests for exceptions must be made by a physician or a clinical professional licensed to prescribe drugs in Vermont.
- Complete this form only if the Office of Vermont Health Access is the primary payer for the drug (not Medicare Part D)
- Do not complete this form for a new prescription for the beneficiary. The Office of Vermont Health Access allows prescribers a shorter initial refill period to test for therapeutic effectiveness and patient tolerance.

Prescribing physician**:**

Name:_____
Phone #:_____
Fax #:_____
Address:_____
Contact Person at Office:_____

Beneficiary:

Name:_____
Medicaid ID #:_____
Date of Birth:_____ **Sex:**_____

Pharmacy **(if known):** _____

1. **Drug Requested:**_____ **Strength, Route & Frequency:** _____
   Anticipated Length of therapy:_____ □ **Brand Name** □ **Generic Equivalent**

2. **Patient's diagnosis for use of this medication:**_____

3. **I am requesting an exception from the required 90 day maintenance fill for this medication because:**

   ☐ **This medication will not be used as maintenance therapy for this patient**
   Anticipated duration of therapy is: _____ weeks/months (please circle)

   ☐ **This patient is not yet stabilized on this medication (an additional 30 day fill will be permitted)**

   ☐ **This patient is homeless and can not store a 90 day supply of medication**

   ☐ **There are extenuating circumstances that justify an exception to the 90 day fill rule:**
   PLEASE ELABORATE: _____
   _____
   _____
   _____
   _____

Prescriber Signature:_____ **Date of this request:**_____